STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155193	A. BUILDING _____ B. WING _____	R-C 11/29/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-GREENWOOD	377 WESTRIDGE BLVD GREENWOOD, IN 46142

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaint IN00118744. This visit was in conjunction with the PSR to the Recertification and State Licensure Survey. Complaint IN00118744-corrected Dates of Survey: November 28 and 29, 2012 Facility number: 000101 Provider number: 155193 AIM number: 100291290 Survey team: Beth Walsh, RN-TC Karina Gates, BHS Courtney Mujic, RN Census bed type: SNF/NF: 162 Total: 162 Census payor type: Medicare: 46 Medicaid: 101 Other: 15 Total: 162 Sample:4 Kindred Transitional Care and Rehab-Greenwood was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2, in regard to the PSR to the Investigation of Complaint IN00118744.	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 000}	Continued From page 1 Quality review completed on December 4, 2012 by Bev Faulkner, RN	{F 000}		